4. has completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the disproportionate share adjustment for safety net providers;
5. is the subject of an appropriation requiring an intergovernmental funds transfer;
6. the public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced at 114.1 CMR 36.07(4)(b)4. above.

(c) Payment to Hospitals under the Adjustment for Safety Net Providers. The Division calculates an adjustment for hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.07(4)(b). This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers is not in effect for any rate year in which Federal Financial Participation (FFP) under Title XIX is unavailable for this payment. The amount payable is also subject to the amount of FFP which continues to be available for this payment.

(d). If a public entity has not met its obligation to make an intergovernmental funds transfer, the Division of Medical Assistance shall have the right to recoup any safety net disproportionate share payment amount which is conditioned on the receipt by the Commonwealth of said intergovernmental funds transfer.

(5) Uncompensated Care Disproportionate Share Adjustment Hospitals eligible for this adjustment are those that report "free care costs," as defined by 114.6 CMR 11.00 and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 11.00. These payments are made to eligible hospitals in accordance with ivision's regulations and the interagency service agreement (ISA) between the Division of Medical Assistance and the Division of Health Care Finance and Policy. Eligible hospitals receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

(6) Public Health Substance Abuse Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000, as limited in DPH's ISA with the Division of Medical Assistance (DMA). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 and DPH's ISA with DMA.

(7) Disproportionate Share Adjustment for Non-profit Acute Care Teaching Hospitals affiliated with a Commonwealth-Owned University Medical School. The Division will determine for FY98 and succeeding years a disproportionate share adjustment for the acute care teaching hospitals that have an affiliation with university medical schools owned by the Commonwealth of Massachusetts.

(a). Eligibility. In order to be eligible for this adjustment, the following conditions must be met:
1. the hospital must enter into an agreement with the state-owned university medical school to purchase medical education, clinical support, and clinical activities from the medical school;
2. the hospital must have a common mission as established by state law, with the state owned university medical school, to train physicians, nurses, and allied health professionals according to high professional and ethical standards and to provide quality health care services;
3. the hospital must have completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance concerning intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for this disproportionate share adjustment;
4. the hospital must be the subject of an appropriation requiring a public entity to make an intergovernmental funds transfer; and.
5. The public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced in 114.1 CMR 36.07(7)(a)3.

(b). Payment amount. The Division calculates an adjustment for eligible hospitals. This adjustment will be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and will equal the amount of funds specified in an agreement between the Division of Medical Assistance and the relevant governmental unit. This disproportionate share adjustment is subject to the availability of federal financial participation.

TN 98-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 5:
114.6 CMR 7.00

114.6 CMR 7.00: ADMINISTRATION OF ACUTE HOSPITAL UNCOMPENSATED CARE POOL UNDER M.G.L. c. 118G

Section

7.01: General Provisions

(1) Scope and Purpose.

(a) 114.6 CMR 7.00 implements the provisions of M.G.L. c. 118G, regarding the acute hospital uncompensated care pool.

(b) The purpose of 114.6 CMR 7.00 is to specify:

1. The rules which will govern payment by hospitals to the pool and payment by the pool to hospitals.

2. The administration of the Uncompensated Care Pool surcharge assessed on payments to hospitals and ambulatory surgical centers.

(2) Authority. 114.6 CMR 7.00 is adopted pursuant to M.G.L. c. 118G.

(3) Organization. 114.6 CMR 7.00 is divided into sections. Each section may be further divided into subsections designated by arabic numerals enclosed in parentheses. A subsection may be segregated into divisions, designated by letters enclosed in parentheses. A division may be further segregated into subdivisions designated by arabic numerals followed by a period.

7.02: Definitions

Actual Costs. All direct and indirect costs incurred by a hospital or a community health center in providing medically necessary care and treatment to its patients, in accordance with generally accepted accounting principles.

Acute Hospital. Any hospital licensed under M.G.L. c. 111, § 51 and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.

Acute Hospital Services. Services listed on an acute hospital's license by the Department of Public Health.

Allowable Free Care Costs. The total free care charges of a hospital multiplied by its cost-to-charge ratio.

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Finance Administration for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 USC § 1395k(a)(2)(F)(I). These services include facility services only and do not include physician fees.

7.02: continued

Bad Debt. An account receivable based on services furnished to any patient which:
(a) is regarded as uncollectible, following reasonable collection efforts, pursuant to 114.6 CMR 10.05, and pursuant to the hospital's established Credit and Collection policy, that conforms with 114.6 CMR 10.09;
(b) is charged as a credit loss;
(c) is not the obligation of any federal or state governmental; and
(d) is not free care.

CenterCare. An ambulatory managed care program that offers primary and preventive health care services to low-income, uninsured adult patients of independently licensed community health centers, administered by the Department of Public Health, pursuant to M.G.L. c. 111, § 24H.

Charge. The uniform price for a specific service charged by a hospital or community health center.

Children's Medical Security Plan. A program of primary and preventive pediatric health care services for eligiblechildren, from birth to age 18, administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24G.

Collection Action. Any activity by which a hospital, community health center or a designated agent requests payment for services from a patient, a patient's guarantor, or a third party responsible for payment. Collection actions include activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy or designee.

CommonHealth. A Medicaid program for disabled adults and disabled children administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E.

Compliance Liability. Pursuant to St. 1991, c. 495, § 56, hospitals which over generated approved revenues under St. 1988, c. 23 are required to pay a portion of such excess revenue into the Uncompensated Care Trust Fund established under M.G.L. c. 118G. For the purpose of 114.6 CMR 7.00, the payment of such excess revenue shall be referred to as a hospital's "Compliance Liability." The Commission is responsible for determining each hospital's Compliance Liability which covers hospital fiscal years 1988 through 1991.

Cost-to-Charge Ratio. A calculation to be used by the Division of Health Care Finance and Policy in determining the uncompensated care pool's liability to each hospital in accordance with M.G.L. c. 118G.

Credit and Collection Policy. A statement, in compliance with 114.6 CMR 10.09, of a hospital's or community health center's general policy and the principles that guide its billing and collection practices and procedures, as approved by its governing board and the Division.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Disproportionate Share Hospital. Any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers and free care.

Emergency Aid to the Elderly, Disabled and Children (EAEDC) Patient. A program of governmental benefits under M.G.L. c. 117A.

7.02: continued

Emergency Care. Medically necessary hospital services provided after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain which a prudent lay person would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to, those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any other such service rendered to the extent required pursuant to 42 USC 1395(dd) qualifies as emergency care for Pool purposes.

Family Income. The sum of annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

Federal Poverty Income Guidelines. The Federal Poverty Income Guidelines published annually by the federal Department of Health and Human Services.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Free Care. Unpaid hospital or community health center charges for medically necessary services which are eligible for reimbursement from the Pool pursuant to the criteria set forth in 114.6 CMR 10.03. Types of free care include: full free care, partial free care, medical hardship, and emergency bad debt.

Gross Patient Service Revenue. The total dollar amount of hospital's charges for services rendered in the fiscal year.

Guarantor. A person or group of persons who assumes the responsibility of payment of (all or part of) the hospital charges for services, but not including third party payers.

Health Insurance Company. A company as defined in M.G.L. c. 175, § 1, which engages in the business of health insurance.

Health Insurance Plan. The Medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization.

Health Maintenance Organization. Company which provides or arranges for the provision of health care services to enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum as further defined in M.G.L. c. 176G, § 1.

Healthy Start. A health care program for pregnant women and infants administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24D.

Hospital. An acute hospital.

Hospital Service Corporation. A corporation established for the purpose of operating a nonprofit hospital service plan as provided in M.G.L. c. 176A.

Indirect payment.

(a) A payment made by an entity licensed or approved under M.G.L. c.175, c. 176A, c. 176B, c. 176G, or c. 176I to a group of providers, including one or more Massachusetts acute care hospitals or ambulatory surgical centers, which group will then forward the payment to member hospitals or ambulatory surgical centers; or

(b) a payment made to an individual to reimburse him or her for a payment made to an acute hospital or ambulatory surgical center.

7.02: continued

Individual Surcharge Payer. A patient or guarantor who pays his or her own hospital or ambulatory surgical center bill and is not eligible to reimbursement from an insurer or other source.

Institutional Surcharge Payer. A surcharge payer that is an entity other than an individual surcharge payer.

Managed Health Care Plan. A health insurance plan which provides or arranges for, supervises and coordinates health care services to enrolled participants, including plans administered by health maintenance organizations and preferred provider organizations.

Medicaid Program. The medical assistance program administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E and in accordance with Title XIX of the Federal Social Security Act.

Medical Assistance Program. The Medicaid program, the Veterans Administration health, hospital, and community health programs and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

Medical Service Corporation. A corporation established for the purpose of operating a nonprofit medical service plan as provided in M.G.L. c. 176B.

Medically Necessary Service. A service that is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include:

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and
(g) the provision of whole blood; provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

Medicare Program. The medical insurance program established by Title XVIII of the Federal Social Security Act.

Payment. A check, draft or other paper instrument, an electronic fund transfer, or any order, instruction or authorization to a financial institution to debit one account and credit another.

Payments subject to surcharge. Direct and indirect payments made by surcharge payers on or after January 1, 1998, regardless of the date services were provided, to:

(a) Massachusetts acute hospitals for the purchase of acute hospital services provided by acute hospitals, and
(b) Massachusetts ambulatory surgical centers for the purchase of ambulatory surgical center services provided by ambulatory surgical centers; provided, however, that payments subject to surcharge shall not include:
1. payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies;
2. payments made on behalf of Medicaid recipients, Medicare beneficiaries, persons enrolled in policies issued pursuant to M.G.L. c. 176K or similar policies issued on a group basis or beneficiaries or recipients of other governmental programs of public assistance.

7.02: continued

3. amounts below the threshold established in 114.6 CMR 7.15(5);
4. payments made by an acute hospital to a second hospital for services which the first hospital billed to a surcharge payer; and
5. payments made by a group of providers, including one or more Massachusetts acute care hospitals or ambulatory surgical centers, to member hospitals or ambulatory surgical centers for services which the group billed to an entity licensed or approved under M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I; and
6. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act, at 5 U.S.C. 8901 *et seq.*

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c.118G, § 18.

Provider. Any person, corporation, partnership, governmental unit, state institution and other entity qualified under the laws of the commonwealth to perform or provide health care services.

Private Sector Charges. Gross patient revenues based on all charges to purchasers and third party payers, including charges under M.G.L. c. 152, exclusive of charges for services to publicly aided patients, charges under Titles XVIII and XIX of the Federal Social Security Act, free care, reduced by all income, recoveries and adjustments, and bad debt, reduced by all income, recoveries and adjustments.

Publicly Aided Patient. A person who receives hospital or community health center care and services for which a governmental unit is liable in whole or in part under a statutory program.

Purchaser. A natural person responsible for payment for health care services rendered by a hospital.

Self-Insurance Health Plan. A plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and administrative costs.

Shortfall Amount. The amount equal to the difference between the total allowable free care costs for all hospitals and the revenue available for reimbursement of free care to the hospitals.

Surcharge Payer. An individual or entity that makes payments for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers; provided, however, that the term "surcharge payer" shall not include:

(a) Title XVIII and Title XIX programs and their beneficiaries or recipients;
(b) other governmental programs of public assistance and their beneficiaries or recipients; and
(c) the workers compensation program established pursuant to M.G.L. c.152. The same entity that pays that hospital or ambulatory care center for services must pay the surcharge. If an entity such as a third party administrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge.

Total Patient Care Costs. Patient care cost as reported by the hospital pursuant to the instructions of the Division.

Uninsured Patient. A patient who does not have a policy of health insurance or is not a member of a health insurance or benefit program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.

7.03: Hospital Reporting Requirements

(1) Required Reports and Filing Dates. Each acute care hospital shall comply with the following reporting requirements:

(a) DHCFP Form UC-97 or any successor form, due no later than 45 days after the last day of the fiscal month for which the report is being submitted;

(b) Its manual or any document, in whatever form, setting forth the hospital's classification of persons presenting for unscheduled treatment, the urgency of treatment associated with each such classification, the location or locations at which such patients might present themselves and any other relevant and necessary instruction to hospital personnel who routinely see patients presenting for unscheduled treatment regarding said classification system. The manual or document must list those classifications which qualify as emergency care under 114.6 CMR 7.00. Such manual or document must be filed with the Division by May 15, 1992. Any subsequent amendments thereto shall be filed with the Division at least 60 days prior to the effective date of the amendment. Such manual or document must be accepted for filing by the Division before it is relied upon by the hospital in claiming any payment from the pool for emergency care;

(c) Each acute care hospital shall file in the UB-92 format, information regarding its free care write-offs. Each acute care hospital shall report the utilization information on the number of inpatient admissions and make a good faith effort to report such information for outpatient visits by the following categories:

1. date of birth;
2. income by reporting the following applicable free care category;
   a. free care;
   b. partial free care; or
   c. medical hardship;
3. primary diagnosis and up to six co-existing secondary diagnoses by ICD-9 for inpatient admissions and for outpatient visits;
4. charges for services rendered;
5. billing number;
6. medical record number (optional); and
7. date of admission and/or date of discharge if inpatient and date of service if outpatient.

In addition, each acute care hospital shall file in the UB-92 format, information regarding its uncollected costs for emergency care to uninsured patients. Each acute care hospital shall make a good faith effort to report the utilization information on the number of inpatient admissions and outpatient visits by the following categories:

a. date of birth;
b. family income by the following categories:
   i. equal to or less than 200% of the Federal Poverty Income Guidelines;
   ii. income between 200% and 400% of the Federal Poverty Income Guidelines; or
   iii. income above 400% of the Federal Poverty Income Guidelines.
c. primary diagnosis and up to six co-existing secondary diagnoses by ICD-9 for inpatient admissions and for outpatient visits;
d. charges for services rendered;
e. billing number;
f. medical record number (optional); and
g. date of admission and/or date of discharge if inpatient and date of service if outpatient.

(d) Each acute hospital shall, upon request, provide the Division or its agent with access to patient account records and related reports.

(e) Each acute hospital shall file or make available information which is required by 114.6 CMR 7.03 or which the Division deems reasonably necessary for implementation of 114.6 CMR 7.00 in accordance with time limits set forth in 114.6 CMR 7.03, or within 15 days from the date of request from the Division, unless a different time is specified in the request. The Division may, for cause, extend the filing date for the submission of reports, schedules, reporting forms, budgets, information, books and records. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

7.03: continued

(f) Reporting requirements for the Uncompensated Care Pool surcharge.

1. Each acute hospital shall report monthly to the Division or its agent the total amount of payments for services received from each institutional surcharge payer who does not appear on either the frequent or infrequent payer list, as defined in 114.6 CMR 7.15(6) and the amount of surcharge payments received from individuals. Hospitals shall report this data in an electronic format specified by the division.

Hospitals shall submit this data by the first business day of the second month following the month during which the payment was received. For example, data regarding payments received in January shall be due to the Division or its agent on March 1.

2. Each acute hospital shall report annually to the Division or its agent the total amount of payments received from each surcharge payer. The Division may waive reporting on payers whose payments to the hospital do not meet a threshold amount established by the Division. Hospitals shall report this data in an electronic format specified by the Division.

(2) Enforcement of Reporting Requirements. If a hospital fails to meet the reporting requirements of 114.6 CMR 7.03(1), the Division may determine that the hospital does not incur any free care expenses for the period for which it fails to meet the reporting requirements. If the Division makes such a determination it will adjust the hospital's liability to or from the uncompensated care pool as calculated pursuant to 114.6 CMR 7.04 to reflect this determination.

7.04: Payments To and From the Uncompensated Care Pool

Each acute hospital shall make payments to or receive payments from the uncompensated care pool in accordance with 114.6 CMR 7.04.

(1) Payments to the Division or its agent shall be made in accordance with instructions from the Division.

(2) Penalties (Effective May 1, 1997). If any part of the hospital's liability amount is not paid 45 days after the due date, the Division will assess a 1.5% penalty on the outstanding balance. The penalty will be calculated from the due date of the invoice. For each month a hospital remains delinquent, an additional 1.5% penalty will be assessed against the outstanding balance, including prior penalties.

(a) Partial payments received from delinquent hospitals will be credited first to the current outstanding liability, and second to the amount of the penalties.

(b) The Division may waive or reduce a hospital's penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the hospital's payment history, the hospital's financial situation, and the hospital's relative share of the payments to the uncompensated care pool.

(3) Division of Medical Assistance (DMA) payment offset: If a hospital does not meet its obligation to make scheduled payments to the uncompensated care pool, and has maintained an outstanding obligation to the uncompensated care pool for more than 45 days, the Division may notify DMA to offset payments on the hospital's Title XIX claims in the amount the hospital's outstanding obligation to the uncompensated care pool, including penalties, plus a 5% late fee on the outstanding amount. Payments offset in accordance with this provision will be credited to the hospital's outstanding liability to the uncompensated care pool. The late fee amount will also be deposited into the uncompensated care pool.

(a) The Division will notify the hospital in writing of the dollar amount to be offset from the hospital's DMA claims. Such notification will be sent to the hospital via certified mail at least ten days prior to notifying DMA. Any dispute by the hospital regarding the payment offset should be made to the Division of Health Care Finance and Policy within this ten day notification period. No dispute by the hospital regarding the payment offset is appealable to DMA.

(b) The Division will notify DMA in writing of the dollar amount to be offset from the hospital's DMA claims.

7.04: continued

(c) Hospitals to which payment is offset will serve all Title XIX recipients in accordance with the contract then in effect with the Division of Medical Assistance, or, in the case of a non-contracting hospital or disproportionate share hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to M.G.L. c. 118G.

(4) Payment schedules (Effective May 1, 1997). Where a financial hardship is determined, the Division may, at its discretion, establish a payment schedule for a given hospital. The payment schedule may include an interest charge.

(a) The interest rate used for the payment schedule will not exceed the prime rate plus 2%. The prime rate used will be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.

(b) A hospital may make a full or partial payment of its outstanding liability at any time without penalty.

(c) If a hospital fails to meet the obligations of the payment schedule, the Division may assess penalties pursuant to 114.6 CMR 7.04 (2) and (3).

(5) Revenue available for payments to hospitals for free care (Effective May 1, 1997).

(a) The revenue available shall consist of revenues produced by hospital assessments under 114.6 CMR 7.04, revenues produced by the Uncompensated Care Pool surcharge under 114.6 CMR 7.15, state appropriations of federal financial participation funds, any other appropriations, and any supplemental funding, less reserves, payments to community health centers under 114.6 CMR 7.04, and uncompensated care pool expenses for activities authorized in M.G.L. c. 118G, § 18.

(b) For FY 1997, supplemental funding shall consist of $15 million transferred from Compliance Liability revenue.

(c) Supplemental funding shall be the primary source of funding for free care to community health centers. If this funding source is insufficient, then revenue provided through other sources will be made available. Any supplemental funding remaining after payments to community health centers will be made available for other purposes of the pool.

(6) Hospitals' Gross Payments to or from the Uncompensated Care Pool. Each hospital's payments to and from the uncompensated care pool shall be based on gross liability to and from the uncompensated care pool. The Division will determine the gross liability of a hospital to or from the uncompensated care pool as follows:

(a) The hospital shall make payments of its gross liability to the uncompensated care pool in accordance with the invoices from the Division. The Division shall make the appropriate gross payment from the uncompensated care pool to the hospital.

(b) The hospital's fiscal year gross liability to the uncompensated care pool shall be calculated as follows:

1. for the time period of October 1, 1991 to September 30, 1992, inclusive, it will be as set forth in St. 1991, c. 495, § 54;
2. for the time period beginning on October 1, 1992, it will equal the product of:
   a. the ratio of its private sector charges to all hospitals' private sector charges; and
   b. the private sector liability to the uncompensated care pool as determined by the general court.
3. for the time period beginning on October 1, 1997, it will equal the product of:
   a. the ratio of its private sector charges to all hospitals' private sector charges; and
   b. the private sector liability to the uncompensated care pool as determined by the general court less $100 million from surcharge payers.

(c) The uncompensated care pool's gross liability to the hospital shall be determined as follows:

1. pool's gross liability to each hospital shall be equal to the total allowable free care costs of the hospital less the pool shortfall allocation;

7.04: continued

2. the total allowable free care costs shall be the product of the cost-to-charge ratio and the total free care charges less free care income, related bad debt recoveries and audit results. Gross free care charges shall not include any sums attributable to free care for which reimbursement is available from other sources including, but not limited to, the Medicare program, foreign health insurance coverage, and a motor vehicle liability policy irrespective of whether such reimbursement has been collected by a hospital. Unpaid Medicare charges, unpaid charges covered by either a foreign health insurance policy or through a foreign governmental health program, and unpaid charges covered by a motor vehicle liability policy shall be considered reimbursable by the pool to the extent allowed under 114.6 CMR 10.00.

3. the pool shortfall allocation shall be the lesser of the product of the ratio of the hospital's total patient care costs to the total patient care costs of all hospitals, multiplied by the shortfall amount or the amount equal to the total allowable free care costs of the hospital.

(d) If a hospital is unable to determine the appropriate segregation of bad debt related to emergency care from the bad debt related to non emergency care for any fiscal year, then the Division shall make an appropriate estimate. If a hospital is unable to determine recoveries, the Division shall estimate the amount of recoveries of bad debt which is attributable to bad debt arising from the emergency care to uninsured patients on the basis of the ratio of the total of the bad debt recoveries to the total of the bad debt.

(7) Interim Calculation of a Hospital's Payment to or from the Uncompensated Care Pool. In order to facilitate timely payments to and from the uncompensated care pool, the Division will from time to time calculate each hospital's payment to and from the uncompensated care pool for a fiscal year by estimating its liability to and from the uncompensated care pool and crediting any payments made to and from the uncompensated care pool for the fiscal year in question. The calculation shall be made according to the following guidelines:

(a) The Division shall notify each hospital of the methodology used to calculate payments and the results of the calculation for the hospital;

(b) If a hospital has not reported data required to calculate the hospital's net payment, the Division may substitute for the required data elements relevant industry averages, prior year reports by the hospital, or other data the Division deems appropriate;

(c) The Division shall adjust payments to reflect the availability of funds, as well as any special payments made under 114.6 CMR 7.04(12).;

(d) The Division may adjust payments to reflect uncompensated care pool expenses for activities authorized in M.G.L. 118G.

(e) The Division may borrow against the penalty, late fee, and interest revenue collected pursuant to 114.6 CMR 7.04(2), (3), and (4) to cover unpaid liabilities until such time as these liabilities may be collected.

(8) Final Calculation of a Hospital's Payment to and from the Uncompensated Care Pool. The final settlement between the uncompensated care pool and a hospital for a fiscal year shall comply with the guidelines set forth in 114.6 CMR 7.04(7) and it shall be as follows:

(a) It shall take place upon completion of the relevant audit and calculations by the Division, for that fiscal year;

(b) It shall be determined using actual private sector charges, final cost-to-charge ratios, and actual free care charges, each having been adjusted for any audit findings;

(c) It shall include reconciliation of any interim payments and estimated liabilities to and from the uncompensated care pool.

(d) The Division may use the penalty, late fee, and interest revenue collected pursuant to 114.6 CMR 7.04(2), (3), and (4) to cover unpaid liabilities from the settlement year that the Division has determined to be uncollectable.

(9) Special Calculation for the Settlement Between the Hospitals and the Pool for the Fiscal Year of October 1, 1991 to September 30, 1992. In order to facilitate timely settlement of payments to and from the pool and to promote fair distribution of pool funds among the participating hospitals, the Division will, for the time period of October 1, 1991 to September 30, 1992, determine the gross free care charges eligible for reimbursement before adjustment as follows:

7.04: continued

(a) For the time period of October 1, 1991 to March 31, 1992, for those hospitals which are not able to determine the amount of bad debt arising from emergency care to the uninsured, the estimate of the amount of the free care charges eligible for reimbursement before adjustment shall be calculated pursuant to the following rules and formulas:

1. the time period of October 1, 1991 to March 31, 1992 shall be designated as "P1";
2. the time period of April 1, 1992 to September 30, 1992 shall be designated as "P2";
3. the free care charges as reported on the form UC-92 (less all income, recoveries and adjustments attributable thereto) shall be designated as "FC";
4. the free care charges as reported on the form UC-92 which are attributable to bad debt arising from emergency care to uninsured patients shall be designated as "EBD";
5. the total bad debt charges as reported on the form UC-92 shall be designated as "BD";
6. the uncompensated care for any period shall be the sum of FC for such time period and BD (less all income, recoveries and adjustments attributable thereto) for such time period and shall be designated as "UC";
7. The ratio of EBDP2 to the sum of FCP2 and BDP2 shall be multiplied by UCP1. This product will be the gross free care charges which are eligible for reimbursement.

(b) For the time period of April 1, 1992 to September 30, 1992 for all hospitals and for the time period October 1, 1991 to March 31, 1992, if such reporting is refiled, for hospitals which are able to specifically segregate bad debt arising from emergency care to the uninsured for the time period October 1, 1991 to March 31, 1992, the free care charges as reported on form UC-92 less all income, recoveries and adjustments attributable thereto, shall be the gross free care charges which are eligible for reimbursement.

(10) Reimbursement of Physicians for the Cost of Free Care. Any hospital which has the status of a disproportionate share hospital pursuant to 114.1 CMR 36.08 and which receives payments from the uncompensated care pool, and such payments are based upon a calculation of the cost-to-charge ratio which includes, provides for, or has an allowance, calculated by the Division, for the cost of free care provided by physicians at such hospital, shall use that portion of the uncompensated care pool payments which is attributable to such cost to reimburse such physicians for such free care.

(11) Updates and Final Settlements. The Division may calculate all updates and make final settlements with hospitals on a net basis. The net shall be the hospital's gross liability to the uncompensated care pool, as determined pursuant 114.6 CMR 7.04(6)(b), minus the uncompensated care pool's gross liability to the hospital, as determined pursuant to 114.6 CMR 7.04(6)(c). If the difference is positive, then that amount shall be the hospital's net liability to the uncompensated care pool; if the difference is negative, then that amount shall be the net liability of the uncompensated care pool to the hospital.

(12) Special Payment. Beginning in FY 1997, the Uncompensated Care Pool will make a one-time payment to hospitals as early in the fiscal year as is administratively feasible. The total amount of this payment to all hospitals will equal the amount of supplemental funding available, less any amount transferred pursuant to 114.6 CMR 7.04(13). This payment will be allocated in accordance with 114.6 CMR 7.04(6), using the preliminary cost to charge ratio. The Division may offset any funds distributed under this section by any amounts owed by hospitals for current or prior years unpaid liabilities. These payments will be included in final settlements calculated pursuant to 114.6 CMR 7.04(8).

(13) Specialty Hospital Exemption. For the Commonwealth's FY 1997 and FY 1998, any specialty hospital that provides free care and whose gross outpatient service revenue equals at least 80% of its gross patient service revenue as of January 1, 1996, shall be exempt from the provisions of 114.6 CMR 7.04. The Division will determine the amount owed for state FY 1997 and FY 1998 by said specialty hospital. The Division will transfer from Compliance Liability revenues into the Uncompensated Care Pool an amount equal to the amount owed by said specialty hospital for state FY 1997 and FY 1998.

7.05: Administrative Review and Adjudicatory Proceeding

(1) Administrative Review. A hospital aggrieved by any action or failure to act by the Division may file an appeal pursuant to the provisions of M.G.L. c. 118G or it may seek a review pursuant to the provisions of 114.6 CMR 7.05.

(2) Administrative Review by the Division. Within 21 days after receiving notice of the Division's determination of a hospital's net payment to or from the pool pursuant to 114.6 CMR 7.04(6), the hospital may request administrative review of the determination. The scope of this administrative review is to consider whether the Division's determination contains any technical errors in the calculation itself or in the data used for the calculation. This administrative review will not consider issues relating to the validity of 114.6 CMR 7.05 or the methodology contained in the regulations for determining a hospital's net payment to or from the pool. Such issues may be raised in a request for judicial review filed pursuant to M.G.L. c. 30A, § 7.

(a) Request for Administrative Review. The hospital's request for administrative review must be submitted in writing to the Commissioner of the Division. The request must describe the technical errors and any necessary corrective actions. If a hospital's request for administrative review does not contain the required information and materials, the Commissioner shall notify the hospital, in writing, that the hospital has ten days from the date of the notice to supply the missing information or materials. If the hospital fails to supply the missing information or materials identified by the Commissioner, the Commissioner shall deny the hospital's request for administrative review.

(b) Administrative Review Process and Decision. Upon receipt of request for administrative review containing the required information, the Commissioner shall refer the matter to a designated employee of the Division for review and decision. The designated employee will review the information and materials supplied by the hospital and may meet or otherwise hold discussions with hospital representatives to clarify certain information. After completing this review, the designated employee will issue a written decision on the hospital's request. The decision will state whether or not any adjustment to the Division's determination of net payment to or from the pool will be made and will give a brief explanation of the reasons for this decision. When such a decision is issued with respect to a calculation made after a hospital's fiscal year has ended and using the hospital's actual audited data for that fiscal year, the decision shall constitute a Notice of Agency Action and shall contain the notice and other information related to adjudicatory proceedings set forth in 801 CMR 1.02(6).

(3) Adjudicatory Proceedings.

(a) Submission of Claim for Adjudicatory Proceeding. Within 21 days of receiving a Notice of Agency Action described in 114.6 CMR 7.05(2)(b), the hospital may submit to the Commissioner of the Division a Claim for Adjudicatory Proceeding to resolve any legal and factual issues raised during any administrative review(s) for that fiscal year. A Claim for Adjudicatory Proceeding must be submitted in writing, must identify the issues of law and fact in dispute between the hospital and the Division, and must describe the evidence presented during administrative review to support the hospital's position. A Claim for Adjudicatory Proceeding cannot raise issues of law or fact and cannot cite evidence that was not considered during administrative review.

(b) Disposition of Claim for Adjudicatory Proceeding. The Commissioner or the Commissioner's designee shall review a Claim for Adjudicatory Proceeding together with the related administrative review decision(s) and any materials in the Division's files related to those administrative review decision(s). If the Commissioner or the designee determines, after the review, that there are no genuine issues of material fact and no issues of law in dispute between the hospital and the Division, the Commissioner shall issue an order dismissing the Claim for Adjudicatory Proceeding, and this order shall constitute a final decision of the Division subject to judicial review under M.G.L. c. 30A, § 14. If the Commissioner or the designee determines, after this review, that there are genuine issues of material fact in dispute between the hospital and the Division, the Commissioner shall issue an order referring the matter to an independent hearing officer designated by the Commissioner to conduct an adjudicatory proceeding in accordance with 801 CMR 1.02 *et seq.* If the Commissioner or the designee determines, after this review, that only legal issues are in dispute between the hospital and the Division, the Commissioner or the designee may